# Clinical Operations Workgroup
# Draft Transcript
# April 22, 2011

## Presentation

**Judy Sparrow – Office of the National Coordinator – Executive Director**
Good morning everybody, and welcome to the Standards Committee's Clinical Operations Workgroup. This is a Federal Advisory call, so there will be opportunity at the end of the call for the public to make comments, and just a reminder to workgroup members to please identify yourselves when speaking.

Let me do a quick roll call. Jamie Ferguson?

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
Present.

**Judy Sparrow – Office of the National Coordinator – Executive Director**
Chris Chute?

**Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards**
Present

**Judy Sparrow – Office of the National Coordinator – Executive Director**
Martin Harris? Dan Huff? David Kates? He was on. Liz Johnson?

**Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics**
I'm here

**Judy Sparrow – Office of the National Coordinator – Executive Director**
Judy Murphy?

**David Kates – Prematics, Inc. – Vice President Product Management**
I'm sorry, I was on mute.

**Judy Sparrow – Office of the National Coordinator – Executive Director**
Liz Johnson's on. Judy Murphy? John Klimek? Wes Rishel? Nancy Orvis? Karen Trudel? Terrie Reed?

**Terrie Reed – FDA/CDRH – Associate Director for Informatics**
I'm here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**
… Busu?

**M**
I'm here.

**Judy Sparrow – Office of the National Coordinator – Executive Director**
Tim Cromwell

**Tim Cromwell – VHA – Director of Standards & Interoperability**
Present.

**Judy Sparrow – Office of the National Coordinator – Executive Director**
Don Bechtel? Joy Sensmeier? Anyone from NIST? Ram Sriram? Did I leave anyone off? With that, I'll turn it over to Jaime Ferguson.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
Thank you, Judy, and thanks everyone for joining today. What I was hoping we could do on today's call is to review what we've heard from Doug at the Standards Committee meeting this week in terms of the outline of work that's to be done over the coming months. One of the things that we discussed also was—so not only the list of standards where recommendations are needed and where different categories of work are needed that were outlined by Doug in various buckets, but also the timing. One of the things that Doug Fridsma expressed, I think, very strongly was a desire to have us look for what he described as low hanging fruit or look for slam-dunk recommendations to the extent that there are any. Try to make those recommendations, perhaps earlier than the schedule that he outlined so that the rulemaking process can proceed for some items while we spend more time deliberating on things that require more deliberation.

What I was hoping to do on this call is first to get an overview of the framework that's been laid out for us by ONC and look for opportunities to prioritize some of that work. So that if there are items that we believe we can make recommendations on relatively easily based on for example existing adoptive standards and previous work in HHS, then we could make some changes to the suggested timeline that Doug laid out for us and, in fact, get on with the matter of making some those early recommendations early.

Then another thing for consideration on this call is the structure of work for the kinds of recommendations that are in scope for this workgroup. We also have the Vocabulary Taskforce as a subgroup of this workgroup, which will be meeting later today. There are a number of items on the list that are suggested for the Vocabulary Taskforce to tackle. So maybe structurally, we'll end up carving off vocabulary items from the Vocabulary Taskforce, but that leaves a relatively large number of items that are outside of that domain for which we may want to structure various task groups, which were, I think, described as tiger teams or—I forget what the other terms were. There were several different terms used in the Standards Committee meetings—but that we may want to convene smaller task groups on some of the particular issues where more work is required.

That's the agenda that I've laid out for this call. Is that okay with everybody? Are there changes? Is that too ambitious or is there something missing?

**M**
Sounds good.

**W**
Yes, I'm good.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
Okay, good. So then, I'm going to refer to the presentation from Doug Fridsma for the Health IT "summer camp" that was presented at the Standards Committee—

**Judy Sparrow – Office of the National Coordinator – Executive Director**
Yes, Jaime, I can send that out quickly in case some people don't have it.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
Okay. It is downloadable on the ONC Website from the meeting materials for the Standards Committee meeting this week, but I'm just going to sort of fly through an overview of it. What Doug laid out was a rulemaking timeline that really requires that we start making standards recommendations within about six weeks from now so that the drafting process for stage two certification and meaningful use rules can take the roughly four month timeline that's required in order to fit into the congressionally mandated schedule for issuing the rules. It's certainly possible that some of the standards that would support some of those

items can't make that timeline and just simply require more work. If that's the case, then they're going to be on to the next round of rulemaking because ONC has made it, I think, pretty clear that they intend to keep to this schedule. Are there any questions on that part of it? Okay.

So the "summer camp" agenda then, involves analyzing and making recommendations on standards that support both the expansion and refinement of the stage one standards, but also things that were considered by the Policy Committee as high-priority or where there was a lot of consensus around the need for particular measures and standards in stage two. Doug very nicely bucketed these into four buckets. Bucket A are performance measures where no standards are needed. Bucket B are standards where standards are needed, but there are sufficient standards and implementation guides that have already been identified and that may be adopted, that may not be adopted, in current rulemaking or in previous rulemaking, but that are relatively easy to adopt basically with little or no analysis work required.

Bucket C is probably where most of the work is for us. This is where there are one or more—in some cases many—existing standards, there's either no implementation guide, or there are many implementation guides that could be identified. That additional public input is needed in order to determine the right path forward, and so we can consider which of the items prioritized by the Policy Committee fall into these buckets. Then the fourth bucket, bucket D, is one where there are no standards that can be identified at this time and that substantial public input is needed and basic standards development is needed.

That's the framework that's been laid out of the four buckets. Any questions on that?

**Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics**
Hey Jaime, on bucket A where it's the performance measure only, will we have any input from this committee on those, or are we strictly focused on those that require a standard?

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
Well, the one area where I think there's been discussion on bucket A is that where bucket A includes quality and/or performance measures that require particular value sets that the Vocabulary Taskforce, I think, needs to consider the inclusion of. For example, enumerated lists of codes that are in those value sets as part of the subsets that we would consider for certification. That is something that I think we need to consider whether to take that approach or not. That's something that, in fact, on our previous call with the Vocabulary Taskforce, Doug Fridsma specifically steered us away from that, but I still think that came up as a discussion item in the Standards Committee, and it's certainly something that we need to consider our approach on that. Does that make sense?

**Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics**
Yes. I'm just trying to—because it sounds like where you're looking is A and C, primarily, in—or at least considering A, right?

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
Well, and we may find things—some of the low hanging fruit or the slam-dunk items may be in bucket B. So it's possible that what we'll end up doing—and maybe what we want to do—is try to identify things that are in bucket B. And see how quickly we can get those recommendations done and completed so that we can then spend most of the time between now and August or September on things where public input is needed. Some refinement of standards may be needed.

**Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics**
Okay.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
Okay. So is that pretty clear still?

**M**
Yes.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
Good. Okay. So Doug had outlined a relatively long list of things in bucket A and several items in bucket B, a few things in bucket C, and relatively little, actually, in bucket D. But the sum total of the list is a relatively long list. So when we compare this with the input that came from Paul Tang from the Meaningful Use Workgroup of the Policy Committee—the ONC list of standards to be recommended is actually much longer than the list of items that the Policy Committee had strong agreement and consensus as priorities for stage two.

So one of the things that we need to consider is in terms of prioritizing both identifying low hanging fruit and prioritizing the work of bucket C is, I think, the relative likelihood of these things actually ending up being in stage two requirements. For example, a few things that the Policy Committee identified as having strong public support and relatively complete alignment on for new objectives in stage two were electronic prescribing for discharge prescriptions, electronic progress notes, electronic medication administration records, patient's provider secure messaging, and recoding patient preferences for communications. So of those things, we may want to consider the standards for e-prescribing of discharge meds, progress notes, and medication administration records as things that we would want to consider in this workgroup. Whereas for example patient-provider secure messaging and recording patient preferences probably are not in scope for this workgroup.

Then there were some other things that the Policy Committee had unclear support on, and basically, there were both agreements and disagreements on whether or not these should be new objectives, and that included advance directives for eligible providers or eligible professionals, viewing and downloading the longitudinal record, listing care team members and having longitudinal care plans. So of those, the viewing and downloading of longitudinal records certainly is something that we could consider parts of that in scope for this group in terms of the content specifications. Then there are standards that can be considered for advanced directives, but I think there's a question, at least in my mind, as to whether or not we should focus resources on those things if there's not clear support for those as stage two objectives.

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
Jamie, with regard to some of those, I think one of the things that's important to recognize is I don't think that the proposal was to come up with a standard for advanced directives, but to be able to indicate whether or not an advanced directive exists. Part of the challenge that we have as we think across these buckets and the like is that there may be some things for which there was a small amount of support or there was some controversy about whether that should be included or not, but I think there is some value in the standards community saying, "If what you wanted to do was to add a check in a transitions of care document that would indicate that this patient has an advanced directive, we believe, from a standards perspective, that's a simple thing to do." We still may decide, from a policy perspective, not to include that as we go forward. But I think part of what the hope is, is that early in this summer, we can have a dialog that basically says, "Here is something that is a high priority from a policy perspective, but it's going to be really, really challenging because standards don't exist," or something.

So we really need to think about how to achieve this policy objective in the short term, building toward the long term solution that may include standards. The converse of that is there may be some things that have equivocal—you need to at least provide the input back to the Policy Committee to say, "This is equivocal, and it's really hard." Or, "I know you guys are equivocal on this, but this is a relatively simple thing, so you don't have to worry about this," in the sense that there are technical limitations or there is a technical barrier to being able to do this.

**Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics**
Doug and Jamie, one of the things on that particular one that I was fascinated by was on the advanced directives—if we're moving to a standard, because in the menu set today, it's an option. It's for 65 and older, but recording advanced directives is already a part of the menu set. So when I saw that, I'm thinking, "Where are we going with that?" We may want to talk more from a conceptual framework

perspective, Jamie, right now, versus a specific standard, but it is a point of recognition that it's already existent.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
I think Doug made a truly excellent point is that if we can go through and identify which of the things on the big list are easy and which are hard, that in and of itself can be valuable input to the process.

**Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics**
Right.

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
And easy from the context of identifying other standards that exist.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
Right—relevant and sufficient standards.

**Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics**
Right

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
What I want to do is, I want to make sure that early in the process we have this dialog between those folks that have clear policy objectives that we all want to reach, and the necessary technical infrastructure so that the standard certification criteria, testing methods—all the pieces that help us get there. So if they have in their mind that an existing standard is out there that will enable this to occur, and in fact, there's a misperception that that standard isn't quite as robust or if there's potential challenges or applying it in this context might be hard. Then part of our responsibility within the Standards Committee is to come up with not only the standards, but also the certification criteria. We may decide that there's not an existing standard that would enable this to happen more quickly or better. But in fact, there may be a way that we could create a certification criteria that demonstrates some functionality or that shows that you can do X, Y, or Z. Feeding that back to the Policy Committee early, I think, is going to be really important so that it doesn't become a waterfall where they say, "Here are our objectives." Then we're faced with a challenge that may not get us as close to the policy objectives because we're locked into an approach that with some dialog back and forth, we could get a better articulation of what the policy would be and align that more closely with the technology to support it.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
Doug, I'm really, really pleased that you mentioned the idea of the functional certification criteria because that, obviously, has been a big discussion point here.

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
That makes sense. Then again, … except for electronic prescribe and discharge meds we can leverage widespread acceptance of some of the NCPDP standards, whereas on the advanced directives and things, we may have to look to ….

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
Yes. Actually, let me go off on a tangent on the discharge meds for a second because in many cases, those are actually filled by the hospital pharmacy using the internal standard that's allowed under Part D of EHL-7 e-prescribing. So I'm not convinced, frankly, that we would want to try to force the hospital systems that have implemented that in conformance with Part D to move to script for internal prescriptions.

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
No. That's a very good point.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

So, Doug, do you have any thoughts on how to finesse that because, obviously, for those that do go out to a retail pharmacy, script is a slam-dunk, right? I hope, but that's not to say that all discharge prescriptions have to have that capability because—and Liz, I don't know what your system does, but certainly a lot of hospital systems that I know of fill those internally.

**Elizabeth Johnson – Tenet Healthcare – VP Applied Clinical Informatics**
Correct. Mostly

**M**
That's pretty much all VA does, Judy.

**Judy Sparrow – Office of the National Coordinator – Executive Director**
Yes and ours is ….

**M**
And I mean then there may be, frankly, other standards that get involved because the claim associated with the discharge meds is handled as more of a retail pharmacy claim and updates information that then can be subsequently used for medication reconciliation. So we may need to investigate not just the clinical transactions around e-prescribing, but how the information conveys which may be in E-35.

**Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards**
One of the things that we can talk about with this is that there is—if you're using a piece of certified electronic health record module, so you've got some certified HIT technology. The reason that we want to create certification criteria is that we want people to use that standard, or they want to use that particular approach, to achieve meaningful use. For example, if what you did is you purchased an EHR that was certified and could generate, for example, a CCR. Then one of the criteria for meeting meaningful use was to be able to exchange that information with a consultant or a healthcare provider using that particular standard.

The challenge that you have is that if you designate a certification criteria that is intended to support one of the policy objectives about exchanging information or whatever, and you then met that objective by sending a pre-text or a PDF or something that was not necessarily interoperable, you're left in that quandary that says you 're supposed to be using certified technology to meet the objectives of meaningful use. If you set up the certification criteria and you disconnect them from their meaningful use, you're never going to achieve the next stage or the next phase after that. Then what we wanted to be able to do is take that CCR and use the information in it to help improve clinical quality and physician support and things like that that, because people aren't necessarily meeting them using the certified criteria.

So I understand the issue, particularly with in-patient and outpatient and what's inside the hospital and what's outside the hospitals for exchange. I think we need to have some conversations and discussions about how best to do that, and that can happen both within the Standards Committee as well as in the Policy Committee. But I think we have to be careful that we want to make sure that there's a tie all the way through, and maybe what is is to say you have to have a certified technology that allows you when you exchange outside your organization to use these standards. If, however, you don't have to exchange outside your organization, it's a little bit challenging just to say—within your hospital your ED system to have to use script to communicate with your pharmacy system, for example.

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
No. That's exactly what we want to avoid, frankly, because specifically there's an alternative standard that's allowed in Part D. We don't want to have meaningful use conflict with Medicare modernization in Part D.

**M**
Exactly, and so I agree with that. What we want to do is we're going to have to try to think through as we think through the certification criteria and the standards to support that. There may be feedback that needs to go back to policy to say, "This is a great policy objective, and here are some standards that we

would identify, but these standards need to be applied in these particular settings. Then in other settings, it's in the hospital, we think that those standards are probably not applicable because they aren't really going to advance your policy objective, and, quite frankly, aren't going to get in the way of some of the other things that we might see coming down the road."

**Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards**
Okay. So Doug, I think you have me almost convinced, and what I'm talking about is when I came into this call, I was thinking that in terms of identifying low hanging fruit and prioritizing our analysis activities, we ought to first consider just those things that the Policy Committee had strong agreement on as stage two objectives. But I think what you're convincing me of is to broaden that to really try to identify low-hanging fruit from your broader list.

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
I think so. Some of the things are going to be—I sort of feel like there's a whole bunch of stuff out there, and I agree, we shouldn't spend a lot of time, money, and energy looking at things that potentially are going to require some work—the bucket C stuff. But I think a very, very quick triage of things to say, "This is something we think is—I know it's low on your priority list, but we think that there's not a lot of technical barriers to this," or we may say, "This is low on your priority list, and it's going to be really, really hard. You may need to make modifications to it if this rises to the level of inclusion." Maybe it shows up on the menu list—to Liz's point. We just need to be, I think, prepared for that, and then once we have a sense for that, that actually can feed back to the policy. They may actually be able to make some reordering or some changes or modifications or whatever, that I think at the end will make a much stronger case, and I think will more tightly connect the objectives that we have in terms of improving patient care quality and improving healthcare delivery by using these things. We don't want to get into the situation where we have one offs-with certification criteria or one-offs with standards that don't really get us to where we want to go.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
So the other question I think, Doug, that came up is in terms of bucket A, on the performance-based measures. I know that, actually, part of the description of that bucket is that no standard is needed, but in fact, in terms of one of the questions that came up is in terms of reporting those measures may require value sets that would provide input to the Vocabulary Taskforce in recommending subsets.

**Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards**
I'd add to that if I might with a recent released this week by NQF of their technical specification, which essentially defines a specification language for performance measures and quality metric offering—quite akin to a machine interpretable issue. I wonder if we would be looking at those as more practical refinements of these measures and therefore revisit things that are presently in bucket A, or just proceed with the bucket A content?

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
Chris, I don't know if this is respondent to that question, but when I think about bucket A, bucket A was primarily in place because there was a focus on standards. But one of the things that Steve Posnack raised during the discussion—and I think is important—is that this notion of certification criteria and testing I think is something that, again, as we think about the whole length between policy to certification criteria, to standards, to testing, we want to go back and make sure that we take a look at the certification criteria and the testing scripts early and work with NIST early on those things. Some of that may be the identification of the value sets associated with that, and also making sure that we've got the quality measures—and potentially the value system might be required for quality measures—included in stuff that we identify as being important.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
Okay. So on our last call with the Vocabulary Taskforce, Doug, the discussion there really revolved around identifying the subsets of the key vocabularies that would be most useful for coordination of care, and actually, specifically not looking at those subsets that would be in the values sets for the quality measures. … on that.

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
I agree on that. The issue is that, suppose you're going to identify a set of … codes that you think are important for a problem list. One would think that if you're going to apply a subset, one way to do that would be to say, "Well, what are the most common problems." But you may want to expand that list to say not only what are the most common problems, but what are the kinds of problems that will be necessary to have for quality measure determination, for example. So expand to create a subset in the vocabulary—and maybe we'll have more time to talk about this this afternoon—but to have a subset of the vocabularies identified that includes not only most common. But also includes other ones that you might deem important because of quality metric assessment, because of public health reporting, because of some of the other things that would be relevant and you would want to have encoded in those terminologies.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
So I think what I heard you say is that, in fact, so we would add to the subsets that are focused on coordination of care. For certification purposes, we would add to those other terms or codes that are used for … quality measures.

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
Yes, that could be potentially an approach to identifying those value sets. One of the things we also what to talk about when it comes to certification criteria and testing strategies is this notion of making sure that people can generate or send highly compliant standards including the value sets that we think are important, but also to be able to receive codes that are not part of that value set and not break and receive, perhaps, malformed standards or standards that aren't necessarily entirely compliant and still not fail, in a sense. To try to begin, if we're moving towards interoperability as one of the strategies, trying to build into our testing and certification criteria some notion of robustness is how that occurs.

**Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer**
Jamie, I just wanted to let you know I joined.

**Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief**
Jamie, I joined about 20 minutes ago.

**Kevin Brady – NIST – Principal Investigator, IIEDM**
Kevin Brady's on from NIST.

**Don Bechtel – Siemens Medical – IT Architect, Standards & Regulatory Mgr.**
Don Bechtel is also here.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
Okay, so I think that's excellent guidance in terms of the prioritizations and thinking about how we would structure some of the recommendations, as well as how we would identify priorities, and how we would go about looking for the low hanging fruit. One of the other questions that we wanted to address on this call is the structure of task groups that are organized to do this work. So the basic idea that I think came up in the Standards Committee a couple days ago, was organizing different tiger teams or task groups out of the Standards Committee on some of these key items.

I'm wondering, Doug, first of all, what's your feeling about the most effective way for us to approach that?

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
Well, I think there's' s a number of action items that came out of the HIT Standards Committee with regard to that, and I think it's going to be clear that given the volume of work that we need to do, we're likely going to have to be highly … in terms of the work that goes on. We probably are going to want to have dynamically organized groups that can work on this stuff that over the course of the summer can accomplish their assessments and evaluations, and then we can disband them or have them sunset as we get into the regulatory phase and ….

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
Well, so let me be blunt in my response to that. That's a really great idea, but you can't have the same people in two places at once.

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
No. I know that. So one of the things that I took away as an action item there is to see if we need to set up some smaller groups and assemble them so that we don't have overlap and we don't have bottlenecks in the process. We've got a lot of good people on the Clinical Ops team, we almost need to distribute them across the entire HIT Standards Committee, augment them with some folks that can help us, and use that as a way to get the boots on the ground, if you will. So I guess what I'm saying is it's probably going to fall to ONC to try to come up with what some of those sub teams might look like. Then to propose that back to you and John and John … just to make sure that we've got the right coverage, and we've got the right numbers of people and things like that. We haven't had a chance to do that since the Wednesday meeting.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
Okay. Well, I guess the other question is we're on the working relationship between these subgroups of the Standards Committee and the S&I frameworks teams because, from your presentation, what I got is that, actually, expect a lot of the work, particularly in bucket C, to be done by the S&I framework and not by the Standards Committee.

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
Potentially. I think that there is a bunch of initiatives that we're going to launch, and we're working on our roadmaps right now within that S&I framework. There are some things that we are going to need boots on the ground to build some things and test them and pilot them. There may be other things that we just simply say, "We do have to resolve a couple of issues, but we think we can over the course of a couple weeks or a couple of months, have some meetings that can help us get to that solution. Or maybe we can use, as I said, the Wikis or other things as a way of broadening the input that we might receive.

I want to make sure that given the amount or work that we have do over the summer, that we utilize all of the various tools at our disposal. In large part, I think the key initiatives that are in the S&I framework, the biggest challenge we have here is that finding the appropriate leadership that can really drive those complex problems home is a challenge, and there is a limited pool of people that have the bandwidth and the talents to be able to do that. So we want to make sure that we use those resources as wisely as we can and not let the inability to find someone who might lead an S&I initiative—a bottleneck.

And without that leadership or that community engagement, one of the things that I said early on with this is that I don't want the kind of discussion and decisions that need to be made to be made in a vacuum or to be made by consultants. I want it to be supported by consultants, but driven by the community. So I'm not sure I'm ready right now to be able to say exactly which things fall into what bucket, but we really have to think about the broader range in distributing the work so that we can get as much done as we can. If it means having a work team within the federal advisory committees paired up with some more robust support and project management or whatever it is to be able to drive some of this through, those are the kinds of things that we've been trying to think through.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
Okay. I guess one other question I should ask is how do you keep that master list of things to be worked on. Is it just what you presented or is there potentially a broader list that considers all of the different objectives that could be in stage two, because that's what you listed, I think, for the Standards Committee was a subset of those.

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
Yes, we tried to be as complete as we could, but not everything certainly was on that list. We have other things related to privacy and security and some of the standards around that. There's work and recommendations that have come around at both organizational and entity level directories. We did

include some work around the NWHIN and some of the governance issues there. Some of that may involve specifications around services or the like that may be important going into the next phase where we talk about interoperability.

The primary focus was around the standards that were tied to the policy and the certification criteria, but there are a host of other things out there as well that are related to direct certificates, directories, exchange NWHIN, all of which may impact the broader HIT … community. I think the Clinical Ops group being able to do this initial set of triage figuring out what are not only the low hanging fruit, but the things that are both important and urgent, that's going to be important early in this phase.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
Okay, I think we do have a call with the Vocabulary Taskforce later today, and so I think that for those things that you've requested that are in the vocabulary realm, we'll really cover those things on that call. In terms of this group then, it seems that there are really just a few of the things that are potentially in bucket B that we would want to consider, so I think you've got the PQRS listed there; that was one of our previous recommendations. So is there anything that's controversial about that for this group? Okay. So it seems like that's a slam-dunk.

I guess another thing that we've discussed here that I think wasn't on your list, but in terms of the discharge medications. Now that's an item that we may want to consider sending back to the Policy Committee for consideration of the hospital/pharmacy transactions, but there are existing standards in both the Script and HL7 that are used in Part D. Does anyone disagree with recommending alignment with those existing adoptive standards?

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
Jamie, before we start going through the list and the like, has everybody on the call had an opportunity to really review and take a look at both the HIT Policy Committee recommendations and some of the list and presentation that we gave on Wednesday?

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
Yes. That's gone out to the group here.

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
Has everybody had an opportunity to review that?

**Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief**
No.

**Christopher Chute – Mayo Clinic – VC Data Gov. & Health IT Standards**
No. and I'm not sure that came to me given my e-mail address ….

**Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief**
Since there's nothing on the … screen, I can't even right now bring up the Judy Sparrow slide deck that you have for this morning Doug. If there's a way to bring that up on the connection, that would be great because—Jamie, this is Nancy Orvis. I want it to be really clear, you mentioned on Wednesday that there were 27 tasks that we were going to have to break up and do things with, and that's the list I'm looking for that I'm not clear where to get. You mentioned that that was how we were—the "summer camp" has gone through these 27 things.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
So, Doug, is that the list of things that you put into the buckets on your slides for Wednesday?

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
I'm not sure.

**Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief**

Isn't that what you said Wednesday? You said they were a list of several tasks that had to be accomplished in the next six months, and that we'd have to break into smaller groups of people to do that kind of work for you?

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
That's correct.

**Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief**
So where is that list of 27 things? I just want to be clear what we need to look at.

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
We have not finalized the list of 27 things.

**Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief**
Oh, so that makes this harder. Okay.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
So I was working off your presentation, which I just counted as 26 things.

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
And when I gave that presentation, this was our first pass. We had a limited amount of time between the HIT Policy Committee and the Standards Committee to go through that whole list.

**Nancy Orvis – U.S. Department of Defense (Health Affairs) – Chief**
Just so you know, in the last ten days we sent you an … a couple use cases that would be applicable to helping clarify something in the next five months, and we need to talk about that too.

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
So one of the questions that I have for the group here is the expectation that ONC will construct the list, finalize the list, and then present it back to this committee? Or is the idea that that list will be triaged or constructed as part of the working group?

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
Well, it seems to me that the list—should the list not be, basically, what we're getting from the Policy Committee?

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
Well certainly, that list is a list of the policy objectives that the HIT Policy Committee would like to achieve, and some of those things are likely going to be involved more than one potentially set of standards.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
Oh, yes. absolutely. But as we just discussed before, I think if there are slam-dunks on that list, even if they don't make it into stage two, we still want to identify them.

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
Yes. There are likely things that are necessary for stage three or that are complementary and part of an overall strategy that need to be included. Enabling technology is not necessarily part of the list exclusively, but that may have other implications. Certainly we have a governance rule that's coming down the road as well, and there's some issues there that we'll probably all have to hold it to the …

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
Yes. So it sounds to me, if I could read back what I think I'm hearing again is that what we need form you, Doug, is the list of things that are, perhaps, things that ONC sees the need for us to work on that are not going to be directly on the Policy Committee list?

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**

… suggest do the bucketing for that too?

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
I think we can help with the bucketing.

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
Okay.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
I think if we get all the folks on the—we have a small group today—but I think if we get all the members of the Clinical Ops group on a call, I think we can have substantial input on the bucketing.

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
And then do you want us to come up with a … for the things that we need from you?

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
Well, I guess my thinking was that we should start here in the Standards Committee with the input from the Policy Committee. So correct me at any point, but I thought we were supposed to start with the input from the Policy Committee in terms of their objectives and consider—so for both identifying low hanging fruit and identifying the priorities and making recommendations around that—that we would start there. But it sounds as if there are things that ONC sees a need for as supporting technologies or things that are coming, perhaps, from another angle—such as other unrelated rulemaking—that would add to that Policy Committee list. Right?

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
Yes. Steve Posnack spent some time describing the proposed approach over the course of the summer. There was a diagram that was presented that showed the relationship between the HIT Policy Committee, the HIT Standards Committee, and ONC. The goal there is that the HIT Policy Committee will make recommendations to ONC. ONC will then, with knowledge of other parts of the federal government, making sure that federal partners and the other kinds of regulatory requirements that ONC has, they would then work with the Standards Committee to flow those and work through the Policy Committee recommendations so that it may include some of those things. It may include all of those things, and may include even additional things that need to be addressed by the HIT Standards Committee.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
Yes, but one of the things that that diagram, frankly, was criticized for in the Standards Committee meeting was that it did not show the direct interactions between the different committees because it just shows all the committees operating independently and not really coordinating. I would include NCVHS on that as well. So one of the things that was proposed in that committee meeting was that there should be more direct communications between the three advisory committees on particular items, not broadly, generally for everything.

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
Sure, and I don't understand the regulations and the policy angle of this as well. I think Steve Posnack could probably or Jodi Daniel could help, but the diagram as presented was the one that was approved. That was the one that was in the HITECH Act, and so we are operating under those auspices. That really requires each of the federal advisory committees to work in a fashion in which they provide recommendations to ONC and then ONC then ….

Hello?

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
I'm still here.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**

Okay, I was just getting static, I guess.

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
I was too.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
Okay. So then I guess in that case, we're just waiting for you to give us the stuff.

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
Okay.

**Stan Huff – Intermountain Healthcare – Chief Medical Informatics Officer**
In that handout, are you going to be offended if we validate that you've covered everything that was in the Policy Committee if we have knowledge in a particular area that augments what you already know? Are you going to feel bad about that, Doug?

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
No. I want to have as much input as I can from the Standards Committee and things like that. I think we need that. It's one of the reasons why I wanted to present the work that we have ahead of ourselves. In some sense, we could've waited until the next meeting because we really only have a few days between the presentations from the HIT Policy and Standards Committee meeting and to incorporate that discussion and to move forward; it's sometimes challenging. But I felt it more important for us to rapidly get some things out and get some feedback so that we can organize that.

I think the thing that's going to be helpful as we go forward through the summer … coordinate going into the various calls and meetings that we have to make sure that we've got all the pieces together that we need. Then, I think, afterwards, there's going to be follow-up and other things that we're going to have to do as well. It's my hope that—I don't want the Policy Committee to throw it over the transom. I want there to be a dialog, but having the HITECH Act define how those relationships … way that we're going to get that dialog and feedback is for us to say, "We've got a whole bunch of these policy recommendations. Let's do a quick review of that stuff, feed that back to ONC. Then we can help make sure that we're meeting the right objectives that we have—not only with the Policy Committee but some of the other activities that are going on both within ONC around governance. As well as some of the things that our federal partners like DOD and DA and … and other things like that—how all those things fit together.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
Doug, when do you anticipate you can get a more complete list to us?

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
We're working on it as we speak to try to do that. I don't know. Do you want us to just do that and throw that over to you, or do you want—

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
Well I would love to talk about it. Also I think, frankly, the reason why we have the Standards Committee membership the way it is (and the workgroups) is because we have a lot of the experts on standards, and so I think you would probably want us to have input on the bucketizing—if you will.

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
Sure. So what that would suggest is that perhaps, Jamie, we probably need to do some coordinating before the next call to make sure that we've got all the things that we need and that if we need to, we can schedule a call in between time. I think we really are going to have to work on developing—doing some work before the meeting occurs, making sure that we've got a work plan that goes out over a couple of weeks, giving people enough time to review some of the materials so that they can provide some valuable input. So maybe we can work with Judy to get a couple of those kinds of calls scheduled in the next week or so, so that when it comes time for the next Clinical Operations Workgroup, we can have both that list finalized and have a pretty good sense for what the decision points need to be.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
Okay. Good. I think that, acutely, we've made a lot of progress on this call, and it sounds like we're going to have some additional coordination by phone calls and e-mails in advance of the next Clinical Operations Workgroup call. Judy, I can't recall when that is scheduled for?

**Judy Sparrow – Office of the National Coordinator – Executive Director**
I don't think we have one, Jamie. I'll get together with Kay today and set something up.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
Okay, but Doug, I think that we can schedule that at a time, then, that works in terms of your schedule for when you think the materials would be together for us to consider and when you want us to have input on the various items.

**Doug Fridsma – ONC – Acting Director, Office of Standards & Interoperability**
Yes. As you know, within my office, we've expanded the number of people that we have. So my hope as well is that we'll be able to have some other members of my team participate in this committee more directly, getting some of that additional work done with regard to the list—the activities that we need to do, the standards that need to be taken care of as well. If you can help with some of those agendas, make sure that we get things queued up, that we've got a way of distributing the work—not only within ONC and the teams that we have here, but also making sure that we've got the right people that are picking and tackling certain subsets of the problem. I think that'll be great. So maybe we'll ask Judy to help arrange a call in the next week or so, so that we can do that.

**Judy Sparrow – Office of the National Coordinator – Executive Director**
Okay.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
Okay. That sounds great. So I think we've covered the agenda for this call, with the exception of public comment, but are there things that we didn't cover that other folks on the call want to bring up or go back to? Okay. Well then, hearing none, I think we're done for this call, and we're ready for the public comment.

**Judy Sparrow – Office of the National Coordinator – Executive Director**
Thanks, Jamie. Thanks everybody. Operator, can you see if anybody wishes to make a public comment.

**Operator**
We do not have any comments at this time.

**Judy Sparrow – Office of the National Coordinator – Executive Director**
Well, thank you, Jamie. Thank you everybody for dialing in.

**Jamie Ferguson – Kaiser Permanente – Executive Director HIT Strategy & Policy**
Thank you everybody for participating here today, appreciate it.